

The challenge of integrality in elderly care in the scope of Primary Health Care

O desafio da integralidade no cuidado ao idoso, no âmbito da Atenção Primária à Saúde

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ABSTRACT This essay is aimed at discussing the challenges of integrality in the care for the elderly, in Primary Health Care, considering the paradigm of functionality, home care and professional training, as an attempt to foster this debate in the scope of collective health.

KEYWORDS Primary Health Care. Health of the elderly. Aging.

RESUMO *Este ensaio objetiva discutir os desafios da integralidade no cuidado ao idoso, no âmbito da Atenção Primária à Saúde, considerando o paradigma da funcionalidade, a atenção domiciliar e a formação profissional, como uma tentativa de fomentar esse debate no âmbito da saúde coletiva.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Saúde do idoso. Envelhecimento.*

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Introdução

Population aging is a reality in many countries, including Brazil, where the number of elderly people, the over-60 population, has significantly grown in the last decades. According to estimates, this age group can reach 73.5 million people in up to 50 years from now, which is more than three times the current population, whose demand for care represents a challenge for the health systems (BORGES; CAMPOS; CASTRO E SILVA, 2015; MIRANDA; MENDES; SILVA, 2016).

The challenge presented results from the fact that the older population has increased in parallel with a substantial increase in the occurrence of Noncommunicable Diseases (NCD), which are one of the main causes of illnesses and death (DANTAS *ET AL.*, 2017). It is important to highlight that the presence of comorbidities is not uncommon in these individuals (SOUSA-MUÑOZ *ET AL.*, 2013). Additionally, it is worth noting the persistence of morbidity caused by infectious, contagious and parasitic diseases, which together with external causes, such as accidents and violence, have made the epidemiologic scenario more complex for the elderly and peculiar to them (DANTAS *ET AL.*, 2017; OLIVEIRA; CRUZ, 2015).

Brazil's current moment, with a severe economic crisis and fiscal austerity policies, can worsen even more the situation of the health of the elderly, as it becomes more difficult to provide social protection for the vulnerable elderly, who demand more attention, especially in the healthcare sector (MIRANDA; MENDES; SILVA, 2016). Thus, issues such as self-care management, longitudinality of care, multiprofessional and intersectorial actions and, above all, integrality, as mentioned in this text, should play a major role in the debates about health services and systems.

Integrality, which is understood in this work in two dimensions, both from the perspective of articulating (preventive and healing) actions to promote health, and from

a holistic view of the biopsychosocial human being, needs to occupy a central place in healthcare provision. Therefore, integrality has to be put into practice by the Brazilian Unified Health System (SUS), especially by the Primary Health Care (APS), which is the main entrance to the system. However, although many successful advances have been made, such as the spread to almost all the cities, the increase in the amount of the population covered and the organization of the Family Health Strategy (ESF), APS still faces some problems, and its scope of action, unlikely what was officially mentioned in the policies, privileges chronic disease management from a predominantly biomedical perspective (AQUINO *ET AL.*, 2014; PELLEGRINI-FILHO; BUSS; ESPERIDIÃO, 2014).

Thus, in spite of the advances and the consolidation of the public health politics, especially those related to APS, guaranteeing integrality in the elderly care remains a huge challenge. This essay is aimed at discussing this issue, considering the functionality paradigm, homecare and the professional training, in an attempt to promote this debate in the area of collective health.

The challenge of Integrality

The organization of the elderly healthcare in the scope of APS should not privilege disease diagnosis and treatment, but, above all, it is important that all those involved provide care to this population group, by also including the promotion of health and preventive and healing actions, which are articulated to guarantee integrality.

There is still a lack of studies that define objectively integrality, which hinders its implementation (NUNES, 2011). In addition, the few authors that tried to define it either did it comprehensively (MATTOS, 2001) or in a limited manner (PINHEIRO, 2001; STARFIELD, 2002). The first case is characterized by what could be called integral practice set – that is, preventive,

healing and health promotion practices – according to a biopsychosocial perspective. The second case restricts the offer of actions and services and also the supply/demand relationship (NUNES, 2011).

Thus, by assuming the difficulty to define integrality, one can try to understand it both as a guiding principle of actions in the health service systems, and as a holistic view of the human being. Therefore, it would contemplate two dimensions – a horizontal and a vertical one. The first one is related to a perspective of an assistance organization, based on the integral practices, in levels of care, with services of low, medium and high technological density, all of them articulated in a reference and counter-reference network. The second one presupposes an enlarged view on the individual, in order to contemplate, in addition to biological issues, different realities that restrict the individual, such as psychic and social realities (CARVALHO, 2013; GIOVANELLA; MENDONÇA, 2012).

The search for integrality has become a challenge in the scope of APS, which makes it difficult to put it in practice (MATTOS, 2001), especially because the biomedical culture, which focuses on medicine treatment with emphasis on outpatient production, is still prevalent in this level of care, as the focus is the disease and its consequences, and not the individuals in all their dimensions. Therefore, a set of needs due to the condition and the specific insertion of the elderly in modern society, such as the exclusion from the job market and the family economic dynamics, as well as loneliness, due to the existence of a few opportunities of leisure and social life or the lack of them, in spite of being frequent, are commonly disregarded (MARTINS *ET AL.*, 2014; ONOCKO-CAMPOS *ET AL.*, 2014; VERAS, 2009).

For the reasons mentioned above, it is necessary to discuss proposals that break with the models focused on the disease, not only regarding the theoretical construct of the policies (in which the process is advanced),

but, above all, in the reality of the health services and in people's lives, by adopting new paradigms for the elderly health care, so as to contemplate the concept of integrality.

The functionality paradigm in the elderly healthcare

In contrast to the biomedical paradigm, which still guides the organization of some practices, even in the APS services, the adoption of the functionality paradigm may be a path to effectively introduce integrality in the care. From this perspective, integrality in the elderly health care surpasses the logic of care based on a logic of complaint-behavior and incorporates the maintenance of functional capacity and the prevention of disabilities (RAMOS, 2009).

Functional capacity, or functionality, can be defined as the ability of the individuals to live independently and autonomously, by adequately developing their daily basic and instrumental activities, based on the interaction of physical, psychocognitive and social attributes (PERRACINI; FILÓ, 2010; VERAS, 2009). Thus, even if the elderly are sick, they can, for example, be considered healthy if they are capable of controlling their illness, so as to avoid after-effects and disabilities, and keep themselves independent and autonomous, based on their own interests (VERAS, 2009).

Based on what has been shown so far, we can think of setting a complete line of care for the elderly. The organization of care into hierarchy is based on the functional capacity, which although its effectiveness lacks empirical evidence (as the proposal is still recent and needs an intersectorial action to be effective), it seems interesting to organize health care in the scope of APS. This happens because, as it is known, the services are often organized based on restricted actions, and approach the individuals with different health profiles in the same way, just because they present the same diseases.

From this perspective, the integrality of the elderly care, in the scope of APS, in fact, needs to incorporate an ample view of the individual. It is necessary to call the health providers' attention to the importance of observing and considering cognitive, humor, mobility and communication aspects as essential domains to health, broadening its scope of action beyond chronic diseases. Undoubtedly, it won't be an easy task, because, besides the biomedical complexity of care, due to multiple morbidities and elderly syndromes that are difficult to manage, it is also necessary to deal with extensive service options offered for different age groups.

Homecare

It is believed that homecare, which is characterized as a set of actions performed at the patient's house for health promotion, disease treatment and prevention, and rehabilitation, with the guarantee of continuous care and integrated with healthcare networks (BRASIL, 2013), is an important initiative to be consolidated, so as to guarantee integrality to the elderly in the scope of APS.

In addition to increasing the autonomy of the elderly and their families, a well-organized homecare can reduce hospitalization and, therefore, potential complications, such as mortality and emotional and financial costs of such episodes. Moreover, it can facilitate the integration of the primary care services with the families and community, which certainly favors the recognition of the needs of the elderly in its different dimensions, and not only from a biological perspective, as it usually occurs in medical offices. Therefore, it is a cost-effective approach, which can also help to guarantee integrality (BRASIL, 2013; FEUERWERKER; MERHY, 2008; LIMA; SPAGNUOLO; PATRÍCIO, 2013).

In a scenario where it is possible to consolidate homecare in the scope of APS, health providers will have the opportunity to care for the elderly in a more qualified manner,

either by means of activities regarding assistance or because of actions aimed at instructing the family about the best way to help their relatives, as family members usually assume the role of health providers, even if they are not adequately prepared for that. In addition, and especially for the elderly, continuous care according to the necessities of the elderly can increase their quality of life (HAYASHI ET AL., 2011; LIMA; SPAGNUOLO; PATRÍCIO, 2013).

Initiatives undertaken in different Brazilian realities show considerable efforts to introduce successful experiences about aging and health of older people in the scope of SUS, in all levels of care, and include APS. After the identification, analysis and cataloging of these initiatives, some were reported based on mapping performed by the Brazilian Ministry of Health, which has released notices for this purpose and certified those with a great potential, based on the judgement of an intersectorial committee with different players. However, although homecare initiatives exist, they are not widely inserted in the dynamics of the services of this level of care.

Yet, Health Community Agents (ACS) and the professionals at the Family Healthcare Support Nuclei (Nasf) play a major role in homecare because of the support they can provide. The agents are important because they identify in the community individual demands of the elderly and their families during the visits to their homes, as well as promote health instruction activities for health providers. Nasf, composed of a multidisciplinary team and with the matrix support, is responsible for establishing health actions together with the health teams and caregivers.

Professional training in the context of aging

The population aging process, as well as their multiple demands, such as the challenge of

integrality in the care for the elderly, surpass the limits of the organization of health services and also drive debates regarding professional competences necessary to deal with this complex reality; therefore, it mostly involves the university education system (CARVALHO, HENNINGTON, 2015; CECCIM; FEUERWERKER, 2004; MOTTA; CALDAS; ASSIS, 2008).

Although SUS is responsible for professional training in the area of health, paradoxically one of the most neglected issues in policy formulation is precisely training. Thus, it is common that professional training be focused on maintaining traditional, biologicist and medicalizing paradigms aimed at procedures, which limit the idea of integrality, but not on surpassing them (CECCIM; FEUERWERKER, 2004).

In general, the elderly are perceived by health providers in a fragmented manner, according to clinical specialties or care groups. In addition, as they usually have multiple morbidities and several demands, it is necessary to involve different medical areas. Ironically, this reinforces care fragmentation for the professionals and the organization of the care networks, which often leads to super specialization.

It is important to note that the change in the professional training is not sufficient to make a substantial change in the care for the elderly, but it is a step forward. It especially involves overcoming a culture that privileges those paradigms, which are endorsed in most of undergraduate schools that train health providers, according to an inadequate logic of care, which does not have a dialog with the principles of SUS, neither confers prestige to it nor promotes integrality.

Final remarks

In Brazil, population aging has its own characteristics and arouses concern in several

sectors, including the health area. Integrality, which is a doctrinaire principle of SUS, is one of the most neglected and paradoxically the one on which the whole system is based.

This essay mentions the necessity of developing alternatives for an integral care for the elderly health that takes into account its complex reality, as well as the fact the health services are not well-prepared, especially in the scope of APS, to deal appropriately with this issue. It is extremely necessary to identify the emergence of new paradigms of care for the elderly that point to a holistic view of the individuals, thereby breaking with care models centered on diseases, and highlight the necessity of preserving functionality, and consequently, the quality of life of the individuals. What is in question in this case is human dignity beyond disease.

The right of the elderly to health requires, as an imperative task of the health system, a better training of health providers, as well as a change in the conceptions that today guide the way we think about health care, especially in the scope of APS, a place in charge of sanitary responsibilities where people, families and communities live and work.

Collaborators

All the authors have substantially contributed to the conception and design of this essay, as well performed a critical review and approved its final version.

Acknowledgement

The authors would like to thank to the Integrated Research Program and Technical Cooperation in Training and Evaluation of Basic Care, of the Collective Health Institute of the Federal University of Bahia, for the institutional support. ■

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Received for publication: April, 2017
 Final version: August, 2017
 Conflict of interests: non-existent
 Financial support: non-existent